The Dermatology Group, Inc.
5298 Socialville-Foster Rd.

Mason, OH 45040
513.770.4212 p
513.770.4213 f

Samir B. Patel, MD
Elizabeth Uhlenhake, MD
Nicole Warner, MD
Danielle M. Waymire, MD
Kristine B. Zitelli, MD

Franceine Potter, PA-C
Seth Stephenson, CNP
Maria Weitfle, CNP

AUTHORIZATION TO RELEASE INFORMATION:

Patient's Name: _____ DOB: _____

Guardian's Name if patient is a minor: _____

Please write the number(s) that we are authorized to call and leave messages

I hereby authorize The Dermatology Group, Inc. to discuss any appointment information, prescription information, lab results, pathology results, and any other information pertinent to my care:

Cell Number: _____ Home Number: _____

Work Number: _____

Email address: _____

Or you may speak with the following person(s):

First Name	Last Name	Relationship to patient
First Name	Last Name	Relationship to patient
First Name	Last Name	Relationship to patient

If you would like to be notified of normal results by email, please go to our website www.thedermatologygroupcincy.com to open up an account.

Please initial here if you wish to decline phone authorization: _____

Comments: _____

I understand that I may revoke this authorization at any time except to the extent that The Dermatology Group, Inc. has already relied on this authorization. I understand that I may revoke this authorization by providing The Dermatology Group, Inc. with a written request for revocation stating my intent to revoke this authorization.

Print Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

Patient ID:_____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety	Depression	Thyroid Problems
Arthritis	Diabetes	Leukemia
Asthma	End Stage Renal	Lung Cancer
Atrial fibrillation	Disease	Lymphoma
Bone Marrow	GERD	Prostate Cancer
Transplantation	Hearing Loss	Radiation Treatment
Breast Cancer	Hepatitis	Seizures
Colon Cancer	High Blood pressure	Stroke
COPD	HIV/AIDS	
Coronary Artery	High Cholesterol	NONE
Disease		

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed	Joint Replacement, Hip (Right, Left, Bilateral)
Bladder Removed	
Mastectomy (Right, Left, Bilateral)	Joint Replacement within last 2 years
Lumpectomy (Right, Left, Bilateral)	Kidney Biopsy (Nephrectomy)
Breast Biopsy (Right, Left, Bilateral)	Kidney Removed (Right, Left)
Breast Reduction	Kidney Stone Removal
Breast Implants	Kidney Transplant
Colectomy: Colon Cancer Resection	Ovaries Removed: Endometriosis
Colectomy: Diverticulitis	Ovaries Removed: Cyst
Colectomy: IBD	Ovaries Removed: Ovarian Cancer
Gallbladder Removed	Prostate Removed: Prostate Cancer
Coronary Artery Bypass	Prostate Biopsy
Mechanical Valve Replacement	TURP (Prostate Removal)
Biological Valve Replacement	Spleen Removed
Heart Transplant	Testicles Removed (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)	Hysterectomy: Fibroids

Hysterectomy: Uterine Cancer NONE

Other _____

Patient ID:_____

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	
		NONE

Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____

Medications: (Please enter all current medications)
_____
_____
_____

Allergies: (Please enter all allergies)
_____
_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never smoked
Former Smoker

Alcohol Use:

EtOH- None
EtOH- less than 1 drink per day
EtOH -1-2 drinks per day
EtOH -3 or more drinks per day

Other_____
Family History (Only first degree relatives)
_____
_____
_____
_____

Preferred Language: _____

Race:_____ Ethnic Group:_____

Preferred pharmacy Name: _____

Phone#: _____

City or Zip code:_____

Patient ID:_____

Review of Systems: Are you currently experiencing any of the following?
(Please check yes or no for the following)

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring/keloids		
Fever or chills		
Cough		
Wheezing		
Shortness of breath		
Rash		
Allergic Rhinitis/hay fever		

Other Symptoms: _____

ALERTS: (please circle all that apply)

Allergy to Adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heartbeat with epinephrine
Are you pregnant or currently trying to get pregnant?